Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Original Public Report

Report Issue Date: January 31, 2023	
Inspection Number: 2023-1415-0001	
Inspection Type: Critical Incident System	
Licensee: Idlewyld Manor	
Long Term Care Home and City: Idlewyld Manor, Hamilton	
Lead Inspector Dusty Stevenson (740739)	**Inspector Digital Signature** Dusty L Stevenson Digitally signed by Dusty L Stevenson Date: 2023.01.31 13:32:27 -05'00'
Additional Inspector(s) Emily Robins (741074)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 4-6, 9-12 2023

The following intake(s) were inspected:

- Intake: [CI: 2931-000007-21] Fall of resident resulting in injury.
- Intake: [CI: 2931-000004-21] Fall of resident resulting in injury.

Inspector Daria Trzos (561) was present during the inspection.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure clear direction was provided to staff who provided direct care to a resident related to use and storage of their assistive device.

A resident's care plan indicated that the assistive device was to be put away after use due to safety reasons. A staff indicated that the assistive device was to be kept at the nursing station. Another staff indicated that the assistive device was to be kept near the dining room for the resident.

The Associate Administrator confirmed the assistive device was to only be used to transfer the resident for a specific purpose and to be put away afterwards. They modified the care plan for the resident to clarify this direction to staff.

Sources: interview with staff, and Associate Administrator; review of resident's care plan

Date Remedy Implemented: January 11, 2023

[740739]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee shall ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

A resident's plan of care indicated that the resident was to have a safety device and to ensure that it was functional. Inspector #741074 observed that the safety device differed from the one specified in the care plan. The Associate Administrator indicated that the resident's care plan should reflect the resident's current needs. The Associate Administrator indicated that this resident may no longer require the specific safety device, but the care plan was not changed to reflect this. Later the same day, the care

plan was revised to reflect the current needs of the resident.

Sources: Resident's Care Plan and Kardex, observation of resident's room, interviews with Associate Administrator.

Date Remedy Implemented: January 12, 2022

[741074]

WRITTEN NOTIFICATION: Binding on licensees

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes when they did not ensure that COVID-19 screening requirements were followed, as laid out in the COVID-19 Guidance: Long-Term Care Homes, Retirement Homes and Other Congregate Living Settings for Public Health Units, effective October 6, 2022.

Rationale and Summary

Residents were to be assessed at least once a day for signs and symptoms of COVID-19. Specifically, COVID-19 screening was not completed for two residents, who required at least daily screening when not in outbreak, and at least twice daily screening during outbreak.

A review of the home's COVID screening assessment record for residents showed that screening was not completed at least daily for two residents in the months of October, November and December, 2022. In the month of October, 2022 two home areas were in COVID-19 outbreak. During this time a resident from one of the home areas was not screened for COVID-19 on four dates, and another resident on another home area was not screened for COVID-19 on three dates.

It was the homes expectation that screening be completed at least daily when not in outbreak and at least twice daily when in outbreak.

As a result, the home may have potentially missed the opportunity to screen residents and reduce the spread of infectious disease.

Sources: interview with DON and Associate Administrator, COVID-19 Pandemic Management Plan, record review COVID-19 Screening tool for residents, CI

[740739]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 10. Hand Hygiene Program, that the licensee shall ensure the hand hygiene program includes access to 70-90% alcohol-based hand rub (ABHR).

Inspectors 740739 and 741074 observed ABHR with expiry dates of August 2022 and November 2022 inside resident rooms in wall mounted ABHR dispensers on two home areas. At the time of observation, residents in the home areas required additional precautions for care and these rooms had expired ABHR.

The IPAC Lead confirmed that expired ABHR should not be used as expired ABHR does not meet the efficacy of the required 70-90% alcohol content required for healthcare. The home's IPAC Policy for the Hand Hygiene Program states that the program will provide a 70-90% ABHR.

Using expired ABHR and therefore failing to provide a minimum 70% ABHR may have increased the risk of transmission of infections.

Sources: observation of expired ABHR, interview with IPAC Lead, Section H of Infection Prevention & Control (IPAC) Policies & Procedures - Subject Hand Hygiene Program
[740739]